



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098 3926

Respondent Name

UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box

Box Number 46

MFDR Tracking Number

M4-12-2054-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Table of Disputed Services: "IC failed to pay per DWC Rule 134.404 Hospital Facility Fee Guideline. Per DWC Rule 134.404, claim pays @ Medicare allowable of DRG 484 \$10,852.35 x 108% = \$11,720.53; Implants (revenue code 278) reimbursed @ cost (\$6,395.20) x 110% \$7,034.72; total allowable: \$18,755.25"

Amount in Dispute: \$7,034.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, it is the Carrier's position: As required per Division of Workers' Compensation (DWC) Rule 134.404, the Carrier has not received, and the requester has not alleged to have provided, the hospital's invoice. The requester did not provide a copy of the bill as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration as required for medical dispute resolution request."

Response Submitted by: UniMed Direct, P. O. Box 262001, Dallas, TX 75026-2001

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011 To March 5, 2011	Inpatient Hospital Surgical Services	\$7,034.73	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”
 - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”
5. 28 Texas Administrative Code §134.404(g) states that “Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.”
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 7, 2011

 - 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
 - 856-103 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

Explanation of benefits dated May 17, 2011

 - 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
 - 901 — RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 856-103 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

Issues

1. Is the carrier's denial reason code 856-103 supported?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent denied the disputed services with reason code 856-103 – “CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.” Review of the submitted documentation finds no additional remittance advice remarks codes or explanations describing the information needed for adjudication. Division rule at 28 TAC §133.3 (a) requires that “any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as ‘insurance carrier improperly reduced the bill’ or ‘health care provider did not document’ or other similar phrases with no further description of the factual basis for the sender’s position does not satisfy the requirements of this section.” No documentation was found to support communication of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. This denial reason is not supported. The Division concludes that the respondent has failed to meet the requirements of 28 TAC §133.3 (a). The disputed services will therefore be reviewed per applicable rules and fee guidelines.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. 28 Texas Administrative Code §134.404(g) states that “Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer’s invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on’s per admission.” 28 Texas Administrative Code §134.404(g)(1) states that “A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: ‘I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.’” Although the requestor asked for separate reimbursement of implantables, the requestor did not submit copies of the manufacturers invoice or other information to substantiate the cost to the facility of the disputed implantables. Additionally, the requestor did not certify that the amount billed represents the actual cost for the implantables.
4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 484 is \$10,852.34. This amount multiplied by 108% is \$11,720.52. The total maximum allowable reimbursement (MAR) is therefore \$11,720.52. The respondent previously paid \$11,720.52, therefore no additional reimbursement is recommended

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	March 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.